LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

200 W. Washington, Suite 301
Indianapolis, IN 46204
(317) 233-0696
http://www.in.gov/legislative

FISCAL IMPACT STATEMENT

LS 6859
BILL NUMBER: SB 201

NOTE PREPARED: Apr 6, 2007
BILL AMENDED: Apr 5, 2007

SUBJECT: Medicaid and Other Health Care Matters.

FIRST AUTHOR: Sen. Miller
FIRST SPONSOR: Rep. C. Brown

BILL STATUS: CR Adopted - 2nd House

FUNDS AFFECTED: X **GENERAL**
DEDICATED
X **FEDERAL**

IMPACT: State

Summary of Legislation: (Amended) This bill changes the timing from twice per year to one time per year for the Drug Utilization Review Board report concerning the preferred drug list (PDL) for Medicaid recipients made to the Select Joint Commission on Medicaid Oversight.

The bill requires the Office of Medicaid Policy and Planning (OMPP) to apply for any Medicaid State Plan amendment needed for the dispensing fee adjustment.

The bill also requires the Office of Medicaid Policy and Planning and a managed care organization (MCO) that has contracted with the Office to reimburse at specified rates for certain emergency room services.

The bill requires the Department of Correction to test an inmate for hepatitis C and HIV 90 days before the inmate is released on parole or probation, transferred to a community corrections or community transition program, or discharged.

Effective Date: July 1, 2007; January 1, 2008.

Explanation of State Expenditures: *Medicaid PDL Reporting Requirement:* The bill changes a requirement for the preparation of a report on the Indiana Medicaid preferred drug list (PDL) for submission to the Select Joint Commission on Medicaid Oversight from twice per year to only once. The Office of Medicaid Policy and Planning reports that the annual cost of producing the PDL report once each year is approximately $56,000. This estimated cost does not include the OMPP staff time required to monitor the production and analysis of the reports. Reducing the number of reports would result in an approximate annual General Fund savings of $28,000 and federal savings of the same amount.

Medicaid Dispensing Fees: The bill requires the Office to apply for an amendment to the State Medicaid Plan if necessary to make an adjustment in dispensing fees. (The Medicaid fee-for-service pharmacy dispensing fee is currently $4.90 per legend drug prescription.) This requirement could be implemented within the current level of resources available to the Office.

Medicaid Payments for Certain Physician Services: This bill would require OMPP and a Medicaid managed care organization (MCO) to pay 100% of the Medicaid fee-for-service reimbursement rates for certain federally required screening exams provided by a physician in an emergency department whether or not those services meet the definition of what a prudent layperson would consider to be an emergency. Emergency department physicians who have executed MCO provider contracts would be excluded from this provision. The bill would result in increased costs to the state to the extent that any increased risk-based managed care costs would be passed through to the state in the annually calculated and negotiated capitated rates.

OMPP has reported that within the PCCM program, the physicians' claims as well as the associated hospital emergency department claims are reimbursed. The fiscal impact of this provision will depend on MCO policy decisions and actions taken to control inappropriate use of emergency departments by their enrollees.

This bill provides for physician payments for federally required hospital emergency department screening exams. OMPP reports that the different federal MCO regulation requires the MCOs to pay for screening exams performed on MCO recipients who meet a prudent layperson's definition of what constitutes an emergency condition. Current Indiana statute requires that physicians who are not contracted with the MCO (i.e., out-of-network providers) must be paid at 100% of the Medicaid fee-for-service reimbursement for medically necessary screening services for MCO patients who present at an emergency department with a medical emergency.

This bill would require the payment for all specified screening exams without authorization of the enrollee's primary medical provider. OMPP has estimated that the bill would require the MCOs to pay for all screening or triage at 100% of the fee-for-service reimbursement for the physician and the hospital regardless of whether the patient met the prudent layperson standard for an emergency condition.

Financially, this requirement would impact the three MCOs differently depending on the contracted status of the emergency department physicians if the organization is currently paying triage fees to contracted providers or denying the claims in total. The fiscal impact of this provision will ultimately depend on actions taken by the individual MCOs to control inappropriate use of emergency departments by their enrollees.

Medicaid managed care operates under a federally approved waiver. The regulation waived is the recipient's freedom of choice. MCO recipients select or are assigned a primary care provider to give the individual a "medical care home". The primary care provider is then responsible for that recipient's preventative and routine care. Controlling the cost of inappropriate use of emergency room services is one of the methods that MCOs use to control costs within the network.

Estimates in prior years have indicated the total cost of this provision would be $1.4 M, or approximately $532,000 in state General Funds. This information is only presented to reference the range of the prior estimated impact on physician costs. However, this estimate does not consider the expansion of mandatory managed care to include the entire state population of TANF, medicaid and CHIP children, and pregnant women. The newly implemented MCO contracts and their network provider contracts have changed as well; there are now only 3 MCOs, each providing statewide coverage. The new MCO contracts took effect on January 1, 2007. Consequently, OMPP does not have adequate claims data under the new system with which

to estimate the potential impact of this bill at this time.

Any denied payments occur within the capitated managed care contracts. The denial of payment does not represent a direct savings or cost to the state since the state pays a capitated amount for each MCO member month regardless of the cost incurred by the MCO for the member's care. The bill would result in increased costs to the state to the extent that increased risk-based managed care costs, which must be actuarially determined, would be passed through to the state in the negotiated rates for the CY 2008 capitation rate. Any fiscal impact related to this bill would be anticipated to result in higher capitated rates only for calendar year 2008.

The Medicaid Program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 38%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 62%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

(Revised) *Hepatitis C and HIV Testing:* This bill is estimated to result in added expenditures of $524,000 each year. Under current law, offenders committed to Department of Correction (DOC) facilities are required to be tested for HIV and for hepatitis C. Offenders testing positive for HIV are required to be retested. As proposed, this bill would require all offenders who are being released on probation or parole, transferred to a community transition or community corrections program, or discharged to be tested for both HIV and hepatitis C. DOC would be required to administer a confirmatory test for any offenders testing positive for HIV.

Retesting offenders would affect both the Department of Health and the Department of Correction. DOC staff collect the blood samples, and Department of Health staff analyze the blood work and report back to DOC.

Added Costs to the Department of Health -- The unit costs for the tests include all reagents and supplies and direct staff costs. Indirect costs related to lab equipment and utilities are not included.

Unit Costs for Administering Tests	HIV	Hepatitis C
Initial Test	$10.55	$20.50
Confirmatory Test	$93.00	

The added costs to the Department of Health are based on these unit costs per test, the number of offenders released in FY 2006 from DOC facilities, and an assumed infection rate of 1% of the offender population. Offenders who test positive for HIV are given a second initial test. If they test positive for the second test, they receive the confirmatory test. In the following table, it is assumed that any offender tested a second time will test positive and require the confirmatory test.

The Estimated Costs of Testing Offenders for HIV and Hepatitis C Who Are Scheduled to be Released from DOC in a 12-Month Period			
All Offenders Released in FY 2006	16,379		
Unit Costs of Initial Tests	$31.05	x	
Costs of Initial Tests			$508,568
All Offenders Released in FY 2006	16,379		
Percent Likely to Test HIV Positive	1.0%	x	
Unit Cost of Confirmatory Test	$93.00	x	
Costs of Confirmatory Test			$15,232
Costs of Tests			$523,800

Added Costs for the Department of Correction – DOC staff indicate that the added costs would be in the form of additional staff to perform the procedure, more forms and blood drawing materials, and added space in some facilities due to overcrowding.

Testing in the facilities would require:

- Identifying the soon-to-be-released offenders, which requires added resources since the earliest expected release date frequently changes.
- Scheduling offenders to be tested. Based on a 365-day calender, almost 45 offenders would be tested each day.
- Explaining the nature of the test, drawing the blood, labeling the tube, and sending the blood to the Department of Health.
- Scheduling and seeing the offender to explain the results and initiate care if indicated.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Office of Medicaid Policy and Planning, Family and Social Services Administration; Department of Health; Department of Corrections.

Local Agencies Affected:

Information Sources: Office of Medicaid Policy and Planning; IC12-15-12-18 ; Hoosier Healthwise, State MCO Contract, Attachment D; MCO Scope of Work; Tim Brown, Department of Correction; Robert Lindner, M.D. Indiana Department of Health.

Fiscal Analyst: Kathy Norris, 317-234-1360 & Mark Goodpaster, 317-232-9852.